3655S.03C

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1468

AN ACT

To repeal sections 375.775, 376.1350, 379.321, 379.362, 379.889 and 379.890, RSMo, relating to commercial lines of insurance, and to enact in lieu thereof five new sections relating to the same subject.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 375.775, 376.1350, 379.321, 379.362, 379.889 and 379.890, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 375.775, 376.1350, 379.321, 379.889 and 379.890, to read as follows:

375.775. 1. The association shall:

(1) Be obligated to the extent of the covered claims existing prior to the date of **[**entry of a decree or judgment pursuant to section 375.560**]** a final order of liquidation or a judicial determination by a court of competent jurisdiction in the insurer's domiciliary state that an insolvent insurer exists and arising within thirty days from the date or at the time of the first such **[**decree, judgment**]** order or determination, or before the policy expiration date if less than thirty days after such date, or before or at the time the insured replaces the policy or causes its cancellation, if he does so within thirty days of such date, but obligation shall include only that amount of each covered claim which is in excess of one hundred dollars and is less than three hundred thousand dollars, except that the

association shall pay the full amount of any covered claim arising out of a workers' compensation policy. In no event shall the association be obligated to an insured or claimant in an amount in excess of the face amount or the limits of the policy from which a claim arises or be obligated for the payment of unearned premium in excess of the amount of ten thousand dollars, or to an insured or claimant on any covered claim until it receives confirmation from the receiver or liquidator of an insolvent insurer that the claim is within the coverage of an applicable policy of the insolvent insurer, except that within the sole discretion of the association, if the association deems it has sufficient evidence from other sources, including any claim forms which may be propounded by the association, that the claim is within the coverage of an applicable policy of the insolvent insurer, it shall proceed to process the claim, pursuant to its statutory obligations, without such confirmation by the receiver or liquidator:

(a) All covered claims shall be filed with the association on the claim information form required by this paragraph no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of insolvency, and an extension of the time to file claims is granted by the court, claims may be filed with the association no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs. In no event shall the association be obligated on a claim filed after such date or on

one not filed on the required form. A claim information form shall consist of a statement verified under oath by the claimant which includes all of the following:

a. The particulars of the claim;

b. A statement that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to said claim;

c. The name and address of the claimant and the attorney who represents the claimant, if any; and

d. If the claimant is an insured, that the insured's net worth did not exceed twenty-five million dollars on the date the insurer became an insolvent insurer. The association may require that a prescribed form be used and may require that other information and documents be included. A covered claim shall not include any claim not described in a timely filed claim information form even though the existence of the claim was not known to the claimant at the time a claim information form was filed;

(b) In the case of claims arising from a member insurer subject to a final order of liquidation issued on or after September 1, 2000, the provisions of paragraph (a) of subdivision (1) of subsection 1 of this section shall not apply and in lieu thereof, such claims shall be governed by this paragraph. All covered claims shall be filed with the association, liquidator or receiver no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of the insolvency, and an extension of the time to file claims is

granted by the court, claims may be filed no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs. The association may require that the prescribed forms be used and may require that other information and documents be included in confirming the existence of a covered claim or in determining eligibility of any claimant. Such information may include, but is not limited to:

a. The particulars of the claim;

b. A statement that the sum claimed is justly owing and that there is not setoff, counterclaim, or defense to said claim;

c. The name and address of the claimant and the attorney who represents the claimant, if any; and

d. A verification under oath of such requested information. In no event shall the association be obligated on a claim filed with the association, liquidator or receiver for protection afforded under the insured's policy for incurred but not reported losses. A covered claim shall not include any claim that is not filed prior to the final date for filing claims, even though the existence of the claims was not known to the claimant prior to such final date.

(c) In the case of claims arising from bodily injury, sickness or disease, the amount of any such award shall not exceed the claimant's reasonable expenses incurred for necessary medical, surgical, X-ray, dental services and comparable services for individuals who, in the exercise of their constitutional rights, rely on spiritual means alone for healing in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof, including

prosthetic devices and necessary ambulance, hospital, professional nursing, and any amounts lost or to be lost by reason of claimant's inability to work and earn wages or salary or their equivalent, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy. Such award may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for himself had he not been injured. Verdicts as respect only those civil actions as may be brought to recover damages as provided in this section shall specifically set out the sums applicable to each item in this section for which an award may be made;

(2) Be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) Allocate claims paid and expenses incurred among the four accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the association under subdivision (1) of this subsection to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under subdivision (6) of this subsection, and other expenses authorized by sections 375.771 to 375.779.

The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member

insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year of the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than one percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or, in the discretion of any such company, credited against future assessments. No dividends shall be paid stockholders or policyholders of a member insurer so long as all or part of any assessment against such insurer remains deferred. Each member insurer may set off against any assessment,

authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made. Assessments made under sections 375.771 to 375.779 and section 375.916 shall not be subject to subsection 1 of section 375.916;

(4) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the director, but such designation may be declined by a member insurer;

(5) Reimburse each servicing facility for obligations of the association paid by the facility and for actual expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this section;

(6) Be subject to examination and regulation by the director. The board of directors shall submit, not later than March thirtieth of each year, a financial report for the preceding calendar year in a form approved by the director; and

(7) Be considered to have been designated commissioner pursuant to subsection 2 of section 375.670, and it shall proceed to investigate, hear, settle, and determine covered claims unless the claimant shall, within thirty days from the date the claim is presented, present a written demand that such claim be processed in the liquidation proceedings as a claim not covered by sections 375.771 to 375.779.

2. The association may:

(1) Appear in, defend and appeal any action on a claim

brought against the association;

(2) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(3) Borrow funds necessary to effect the purposes of sections 375.771 to 375.779 in accord with the plan of operation;

(4) Sue or be sued;

(5) Negotiate and become a party to such contracts as are necessary to carry out the purpose of sections 375.771 to 375.779;

(6) Perform such other acts as are necessary or proper to effectuate the purpose of sections 375.771 to 375.779;

(7) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year; and

(8) Become a member of the National Committee on Insurance Guaranty Funds.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of

care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services<u>; except that, health benefit</u>

plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either

requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer- reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any

combination of the foregoing;

(28) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

(30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not

include elective requests for clarification of coverage;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500, RSMo.

379.321. 1. Every insurer shall file with the director, except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section, every manual of classifications, rules, underwriting rules and rates, every rating plan and every modification of the foregoing which it uses and the policies and forms to which such rates are applied. Any insurer may satisfy its obligation to make any such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the director to accept such filings on its behalf, provided that nothing contained in section 379.017 and sections 379.316 to 379.361 shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or as requiring any member or subscriber to authorize the director to accept such filings on its behalf. Filing with the director by such insurer or licensed rating organization within ten days after such manuals, rating plans or modifications thereof or policies or forms are effective shall be sufficient compliance with this section.

2. Except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section **[**and inland marine risks as provided in subsection 1 of this section**]**, no insurer shall make or issue a policy or contract except pursuant to filings which are in effect for that insurer or pursuant to section 379.017 and sections 379.316 to 379.361. Any rates,

rating plans, rules, classifications or systems, in effect on August 13, 1972, shall be continued in effect until withdrawn by the insurer or rating organization which filed them.

3. Upon the written application of the insured, stating his or her reasons therefor, filed with the insurer, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

4. Every insurer which is a member of or a subscriber to a rating organization shall be deemed to have authorized the director to accept on its behalf all filings made by the rating organization which are within the scope of its membership or subscribership, provided:

(1) That any subscriber may withdraw or terminate such authorization, either generally or for individual filings, by written notice to the director and to the rating organization and may then make its own independent filings for any kinds of insurance, or subdivisions, or classes of risks, or parts or combinations of any of the foregoing, with respect to which it has withdrawn or terminated such authorization, or may request the rating organization, within its discretion, to make any such filing on an agency basis solely on behalf of the requesting subscriber; and

(2) That any member may proceed in the same manner as a subscriber unless the rating organization shall have adopted a rule, with the approval of the director:

(a) Requiring a member, before making an independent filing, first to request the rating organization to make such filing on its behalf and requiring the rating organization,

within thirty days after receipt of such request, either:

a. To make such filing as a rating organization filing;

b. To make such filing on an agency basis solely on behalf of the requesting member; or

c. To decline the request of such member; and

(b) Excluding from membership any insurer which elects to make any filing wholly independently of the rating organization.

5. Any change in a filing made pursuant to this section during the first six months of the date such filing becomes effective shall be approved or disapproved by the director within ten days following the director's receipt of notice of such proposed change.

6. Commercial property and commercial casualty requirements differ as follows:

(1) All commercial property and commercial casualty insurance rates, rate plans, modifications, and manuals of classifications, where appropriate, shall be filed with the director for informational purposes only. Such rates are not to be reviewed or approved by the department of insurance as a condition of their use. Nothing in this subsection shall require the filing of individual rates where the original manuals, rates and rules for the insurance plan or program to which such individual policies conform have already been filed with the director;

(2) If an insurer will only renew a commercial casualty or commercial property insurance policy with an increase in premium of twenty-five percent or more, a "premium alteration requiring notification" notice must be mailed or delivered by the insurer

at least sixty days prior to the expiration date of the policy, except in the case of an umbrella or excess policy the coverage of which is contingent on the coverage of an underlying policy of commercial property or casualty insurance, in which case notice of an increase in premium of twenty-five percent or more shall be mailed or delivered at least thirty days prior to the expiration date of the policy. Such notice shall be mailed or delivered to the agent of record and to the named insured at the address shown in the policy. If the insurer fails to meet this notice requirement, the insured shall have the option of continuing the policy for the remainder of the notice period plus an additional thirty days at the premium rate of the existing policy or contract. This provision does not apply if the insurer has offered to renew a policy without such an increase in premium or if the insured fails to pay a premium due or any advance premium required by the insurer for renewal. For purposes of this section, "premium alteration requiring notification" means an annual increase in premium of twenty-five percent or more, exclusive of premium increases due to a change in the operations of the insured which increases either the hazard insured against or the individual loss characteristics, or due to a change in the magnitude of the exposure basis, including, without limitation, increases in payroll or sales. For commercial multiperil policies, no "premium alteration requiring notification" shall be required unless the increase in premium for all of a policyholder's policies taken together amounts to a twenty- five percent or more annual increase in premium;

(3) Commercial property and commercial casualty policy

forms shall be filed with the director as provided pursuant to subsection 1 of this section. However, if after review, it is determined that corrective action must be taken to modify the filed forms, the director shall impose such corrective action on a prospective basis for new policies. All policies previously issued which are of a type that is subject to such corrective action shall be deemed to have been modified to conform to such corrective action retroactive to their inception date;

(4) For purposes of this section, "commercial casualty" means "commercial casualty insurance" as defined in section 379.882. For purposes of this section, "commercial property" means property insurance, which is for business and professional interests, whether for profit, nonprofit or public in nature which is not for personal, family or household purposes, and shall include commercial inland marine insurance, but does not include title insurance;

(5) Nothing in this subsection shall limit the director's authority over excessive, inadequate or unfairly discriminatory rates.

379.889. [1. The effective date of a commercial casualty insurance filing required to be submitted to the director for review shall be the date specified therein, but not earlier than sixty days after the filing is received by the director. If the director has reviewed the filing prior to expiration of the waiting period, the director may authorize an effective date prior to expiration of the waiting period but not earlier than the date such written application is received. If the director has not approved or disapproved the commercial casualty insurance

filing within the sixty-day period after the filing is received by the director, the filing shall be deemed approved until such time as the director disapproves the filing.

2. The director shall only approve**]** Commercial casualty insurance **[**filings that are not**]** rates shall not be excessive, inadequate or unfairly discriminatory. No rate shall be held to be excessive unless such rate is unreasonably high for the insurance coverage provided. No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses or unless such rate is unreasonably low for the insurance coverage provided and the use of such rate has, or if continued will have, the effect of destroying competition or creating a monopoly. Unfair discrimination shall be defined to include, but shall not be limited to, the use of rates which unfairly discriminate between risks in the application of like charges or credits or the use of rates which unfairly discriminate between risks having essentially the same hazard.

379.890. Supporting actuarial data shall **[**accompany every**]** be filed in support of a commercial casualty insurance rate, rating plan, or rating system filing, whenever requested by the director to determine whether rates are excessive, inadequate or unfairly discriminatory. The data shall be in sufficient detail to:

(1) Justify any rate level changes; and

(2) Demonstrate the statistical significance of differences or correlations relevant to rating plan definitions and rate differentials.

[379.362. 1. Commercial property insurance and commercial casualty insurance policies shall be exempt from those provisions of sections 379.316 to 379.361, sections 379.420 to 379.510 and section 379.888 which concern regulation by the department of policy language, policy provisions or the format of such policies, or the rates associated with such policies, for any policy for which the policyholder certifies in writing, on a certification form approved by the department, that the policyholder understands that the policy's language or the policy's rating is unregulated by the department and that the requirements of either subdivision (1) or subdivision (2) below are met:

(1) The policyholder has utilized the services of the independent insurance adviser. For purposes of this section, the term "independent insurance adviser" means a person who is qualified through education, training or experience to assess the purchaser's insurance needs and analyze the policy with or on behalf of the policyholder. Such an insurance adviser may be an employee of the policyholder or a person retained by the purchaser, provided that the independent insurance adviser shall not also be an employee of the insurer. Such an independent insurance adviser shall only be compensated for services related to the insurance transaction in question by the policyholder; or

(2) The policyholder's commercial operations meet any two of the following criteria:

(a) One hundred or more employees;

(b) A net worth of over twenty-five million dollars;

(c) Net revenues or sales of over fifty million dollars;

(d) Paid aggregate annual commercial insurance premiums of over fifty thousand dollars, excluding workers' compensation and employer's liability insurance;

(e) Is a not-for-profit or public entity with an annual budget or assets of at least twenty-five million dollars; or

(f) Is a municipality with a population of over fifty thousand inhabitants.

2. An insurer writing a commercial property or commercial casualty insurance policy pursuant to subsection 1 of this section shall retain a copy of the policyholder's written certification as part of the insurer's policy records of the transaction.

3. Nothing contained in subsection 1 of this section shall be construed as exempting commercial property or commercial casualty policies which meet the

requirements of subsection 1 of this section from any regulatory authority of the director of the department of insurance other than that authority related to the oversight of the policy language, policy provisions or the format of policies, or of the rates used to calculate the amount of premium charged. In particular, nothing contained in subsection 1 of this section shall limit the director's authority over excessive, inadequate or unfairly discriminatory rates.

4. The director may, by rule, require insurers providing coverage pursuant to subsection 1 of this section to retain information in such insurer's files identifying the policies providing such coverage, and to report to the department aggregate data regarding the types of such coverage written and the amounts charged for such coverage.

5. Notwithstanding the provisions of section 384.017, RSMo, commercial property or commercial casualty insurance meeting the requirements of subsection 1 of this section may be procured through a surplus lines licensee from an eligible surplus lines insurer even though the same type of coverage or quality of service is obtainable in the market from admitted insurers.**]**